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ABSTRACT

The Health Systems Agencies created to plan and coordinate the development of health care systems in 205 health service areas across the states have a need to be legitimized and operationalized in community contexts in order to achieve their purpose. Community psychologists have both research and consultation roles to play in contributing to understanding of these agencies and to their effective performance. Specific tasks exist for participating psychologists, particularly the guidance of agency self-assessments. Involvement in regional health planning may also stretch the perspectives of community psychologists. (Author)

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Applications of Community Psychology in Fostering the Development of Health Systems Agencies

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As students and intended shapers of community processes affecting both individual outcomes and collective action, community psychologists in the States face an interesting new phenomenon in the emergence of areawide health planning organizations designated by the Secretary of HEW as Health Systems Agencies (HSA's). Though they have ancestors in comprehensive health planning agencies, regional medical programs and hospital planning councils, the 1974 Health Planning Act broke new ground in authorizing a single agency for each area charged with (1) developing a health system plan and annual implementation plans, (2) reviewing proposals for system change and periodic reviews of existing services for appropriateness, and (3)designing and promoting projects which achieve plan objectives. This act recognized HSA's as the primary building blocks in a coordinated national system of health care planning.

Though created and invested with some powers under Federal authority, the new agencies must also have local sanction and acceptance if their plans are to lead to actual changes in the structure and in the utilization of health services. Recognizing this, the congress designed the agencies to be governed by volunteers who will represent the full spectrum of actors concerned with health care, and required that from 51 to 60 per cent of governing boards be consumers as opposed to providers of services. The legislation also provides that the agency will not be a provider itself, but will promote the implementation of its plans by other entities through the provision of technical assistance

and development funds. Thus, the design is for an HSA to be a technical resource to an areawide community's efforts to conduct participative planning which might fit both Federal policy objectives and newly articulated local interests. In initiating such a planning process, HSA's intrude directly into the way health care system decisions are made. They add many new voices to such deliberations, and invoke the interests of the area's population at large as counterposed to the interests of the provider institutions and professional groups which have heretofore prevailed. Moves which shake up the community's institutional structure tend to encounter active resistance in proportion to their perceived likelihood of success. Even if not directly challenged, the adjustments required are often sufficiently great that community members from both the traditional elites and previously under-represented constituencies need new knowledge, skills, and support to cope with the changing ground rules.

This is particularly true when a health planning area is comprised of geographically dispersed, and socially diverse communities with little prior recognition of a regional identity and very few active intercommunity bonds. Another complication arises when values antithetical to planning are widely held in an area. One common value issue rests on the assumption that planning is socialistic and invasive of freedom. Another stems from the traditional deference given to the opinions of physicians and a reluctance to think critically about community service institutions. This issue is sometimes cast in terms of loyalty.

These introductory comments, I trust, have made it clear

that the embedding of an HSA and its planning task within the social processes of an area community must be understood as an exercise in community and intercommunity development, a matter of reshaping institutional patterns. Community psychologists may contribute to this process along with other social scientists who focus on understanding and sometimes guiding community choices and activities.

What Are the Tasks and Roles?

There are a variety of combination roles with differing weights assigned to research consultation. Most of them likely involve a professional relationship with the leadership of an HSA, both staff and volunteer governance structure. In making this the primary point of access, however, one does not necessarily accept an obligation to advocate or to pursue only the objectives as perceived by agency leaders. The overriding loyalty is to the interests of the total area as they may be independently viewed or as they emerge from the give and take of discussion amongst participants from diverse constituencies. One consultant function may be to help leaders hear and understand diverging views. Another may be to help them to see the necessity of community linkage to the viability of an HSA and its planning process. The following list illustrates the range of other tasks to which community psychologists may contribute their skills.

1. Providing information about the distribution of perceptions, opinions, and values concerning the delivery of health services and areawide health planning. Such information,

along with estimates of its validity, may be an input to agency leadership and/or to the community at large. In their raw form these data may not be optimally useful. Community psychologists rather than mere survey technicians can be interpreters of data in the context of conceptions of community well-being or ideas about facilitating collective action.

2. Mapping the network of stake-holders in health care decision making and testing the adequacy of present and proposed ideas about the composition of governing boards and committees against models of community structure in the health planning area. Identifying key actors. Promoting the development of the network as a co-acting collectivity and of individual network members as more active and effective participants.

3. Guiding the development of data-based scenarios which describe predicted outcomes associated with various configurations of the health care system in such a way that real choices are depicted. This involvement in the substance of health planning may be an important aid to establishing the legitimacy of the HSA and its function. If the agency can articulate clear choices and their likely consequences, it can involve the public in the planning process and demonstrate that the process is not dominated by some conspiratorial cabal. Community psychologists may aid in the design of processes to reach various segments of the community and to

provide ways for them to register reactions.

4. Consulting on the conduct of meetings, the design of decision processes, and the facilitation of organizational work. Action research studies of participant reactions and of the quality of decisions may be the basis for constructive organizational inputs.

These four examples provide some indication of the types of work that may need to be done to promote community linkage. They neither exhaust the options nor are necessary inclusions in the set of tasks to be performed. To avoid fixating at the level of this once-over-lightly examination of possibilities, I would like to take a slightly closer look at one more alternative.

Agency Self-Assessment and the Developmental Process

In guiding the selection of steps toward the establishment of sanctioned new processes for making decisions about health care delivery, it is useful for an HSA to monitor its progress on selected key dimensions. Data on the agency's standing may redirect the allocation of effort or lead to corrective adjustments in strategies. A consultant may therefore be useful in designing procedures both for the collection of data and for its deliberate use in planning an institution building strategy. I have recently developed a preliminary form of an HSA Self-Assessment and Development Planning Guide. It is designed to obtain ratings along a set of dimensions in terms of the respondents' views of (a) the present status of the agency on each scale, (b) a reasonable

aspiration for the agency's position on that scale, and (c) the importance of each dimension.

The dimensions are selected in terms of a still crude concept of the developmental process. While data from the instrument may provide useful first approximations to an agency's developmental status, comparative analysis may laso help toward the development of a more systematic and comprehensive way of thinking about these processes. The dimensions include:

1. Legitimacy: The degree to which the HSA is acknowledged as the legitimate coordinator of system decision making for the health planning area.
2. Centrality: The degree to which the HSA is actively and visibly involved in deliberations and decisions concerning the area health care system and its components.
3. Quality of Representation: The degree to which those involved in agency governance include representatives of all sectors of the health care system and community constituencies.
4. Mission Clarity: The degree to which people in governance positions have a clear idea of the agency's role in developing the area's health system and of how the agency fits into an integrated national health planning system.
5. Mission Feasibility: The degree to which goals and strategies are realistic in relation to resources available and agency capabilities.
6. Initiative: The degree to which the agency takes an active stance in building external relationships and advancing the implementation of HSA goals.

7. Leadership Consensus: The degree to which leaders concur on fundamental choices concerning strategies and operating style.
8. Quality of Board-Staff Relationships: The degree to which relations between volunteers and staff members are marked by mutual understanding and reciprocal influence.
9. Work Organization: The degree to which the task activity is clearly and coherently structured.
10. Quality of Volunteer Participation: The degree to which volunteers serving on the board, committees, and SAC's are informed and skillful in contributing to the work of the HSA.
11. Quality of Staff Contribution: The degree to which the professional staff provides the breadth and depth of technical expertise, administrative and communications skills, and sound judgment required to support agency accomplishment of its objectives.
12. Commitment: The degree to which volunteers and staff members are personally invested in the success of the agency.
13. Resource Allocation: The degree to which the allocation of agency resources corresponds to a clear and rational strategy.

This self-study process begins with individual responses from a wide selection of people internal and external to the agency. The individual data are then tabulated and organized as material for discussion. Items on which there are large discrepancies between present and aspired ratings, and which are rated

as important are given priority to be selected as foci for developmental planning. This process may be repeated periodically as a way of encouraging informed self-guidance in agency development. Its pursuit requires consultative guidance in designing and managing the process. The consultant needs to have skills in designing studies and handling data, skills in designing social processes, and at least a provisional model of what it takes for an HSA to function in its community setting. In these requirements, the management of self studies may be prototypical of demands placed upon consultants who become involved in promoting the development of HSA's or their functional equivalents as community resources.

Characteristics of this Form of Practice

While the practice of community psychology in the development of this type of agency may not be unusual in many respects, there are some features which set it apart:

(1) The extension of community work to multi-community and intercommunity processes. Health planning areas typically involve large populations, multiple political jurisdictions, and diverse geographic features (e.g. rural-urban settings). Linkage must be made with both the parts and some conception of the whole as a unified entity for health planning purposes. Success requires that some modicum of a regional identity and the ability to deal with issues of equity and efficiency of service provision within a larger sphere be developed among participants and their constituents.

(2) Statutory Sanction for a Workable Form of Citizen Participation. The planning law not only requires broad partici-

pation, but provides specific guidglines for the composition of governing bodies and their functions. The participative model is operational and real -- playing for keeps rather than cooling out the community. While success is not assured by the sound design alone, its credibility makes the task of meaningfully involving citizens feasible. It can be looked upon as a generalizable to other spheres of community action.

(3) A Feasible Planning Structure. The planning process envisioned in the law provides a way for people to make data-bases, value-linked decisions about what they want and need in the context of information about costs and prospective benefits. Technical support for planning is provided. The area effort is linked into a federalistic system in such a way that the process can be taken seriously. While there are many ways in which the process can abort, the law does set up a technically feasible framework for planned community action. In that sense it provides an often-missing ingredient, a legally legitimate structure.

(4) The Centrality of Health Concerns. The health field is pervasively intertwined with many other dimensions of community concern and activity. As people learn to think about health promotion and disease prevention as well as access to therapeutic resources, the field ramifies into all the dimensions of personal life style choices and community characteristics. Health planning can therefore be an appropriate leading edge for community mobilization and informed societal self guidance. If this process is made to work, the side benefits for community integrity

and guidance capacity may be substantial.

The passage of the National Health Planning and Resource Development Act of 1974 creates an opportunity for an important step forward in promoting community involvement in societal steering for an important sphere of activity. Its implementation through the creation of HSA's which are thoroughly linked with their constituent communities will require consultative assistance to the agencies and their communities. Community psychologists may have important roles to play in helping this happen.